Behavioral Health Services

Greater Arizona RFP

Databook

Introduction, Report Descriptions, Adjustments to Data, and Rate Setting Methodology

Prepared by:
Mercer Government Human Services Consulting

For:
Arizona Department of Health Services
Division of Behavioral Health Services

Introduction

Background

As part of the Arizona Department of Health Services/Division of Behavioral Health Services (DHS) behavioral health procurement process, prospective Offerors are furnished with a copy of this databook. This databook presents several data elements including:

- Demographic Data (Eligibility & Enrollment Tables);
- Encounter Data;
- Financial Data;
- Diagnosis Prevalence Data;
- Zip Code Distribution Information
- Complaint Resolution Data; and
- Grievance and Appeals Data.

Data is presented for the following populations:

Category of Aid	Children	SMI	GMH/SA
Title XIX	X	X	X
Title XXI	X	X	
Title XXI — HIFA II		X	X
Title XIX — DDD-ALTCS	X	X	X
Non-Title XIX/XXI	X	X	X

The Covered Behavioral Health Services Guide defines and describes the service category criteria used for each of the service categories shown in the appropriate sections of this databook. Please refer to the Covered Behavioral Health Services Guide for additional information.

This databook provides data for Greater Arizona, which includes all counties in Arizona except Maricopa County. The following table indicates the counties included in each Geographic Service Area (GSA).

Geographic Service Area	Areas Served
GSA 1	Apache, Coconino, Mohave, Navajo, and Yavapai Counties
GSA 2	LaPaz and Yuma Counties
GSA 3	Cochise, Graham, Greenlee, and Santa Cruz Counties
GSA 4	Gila and Pinal Counties
GSA 5	Pima County

Purpose

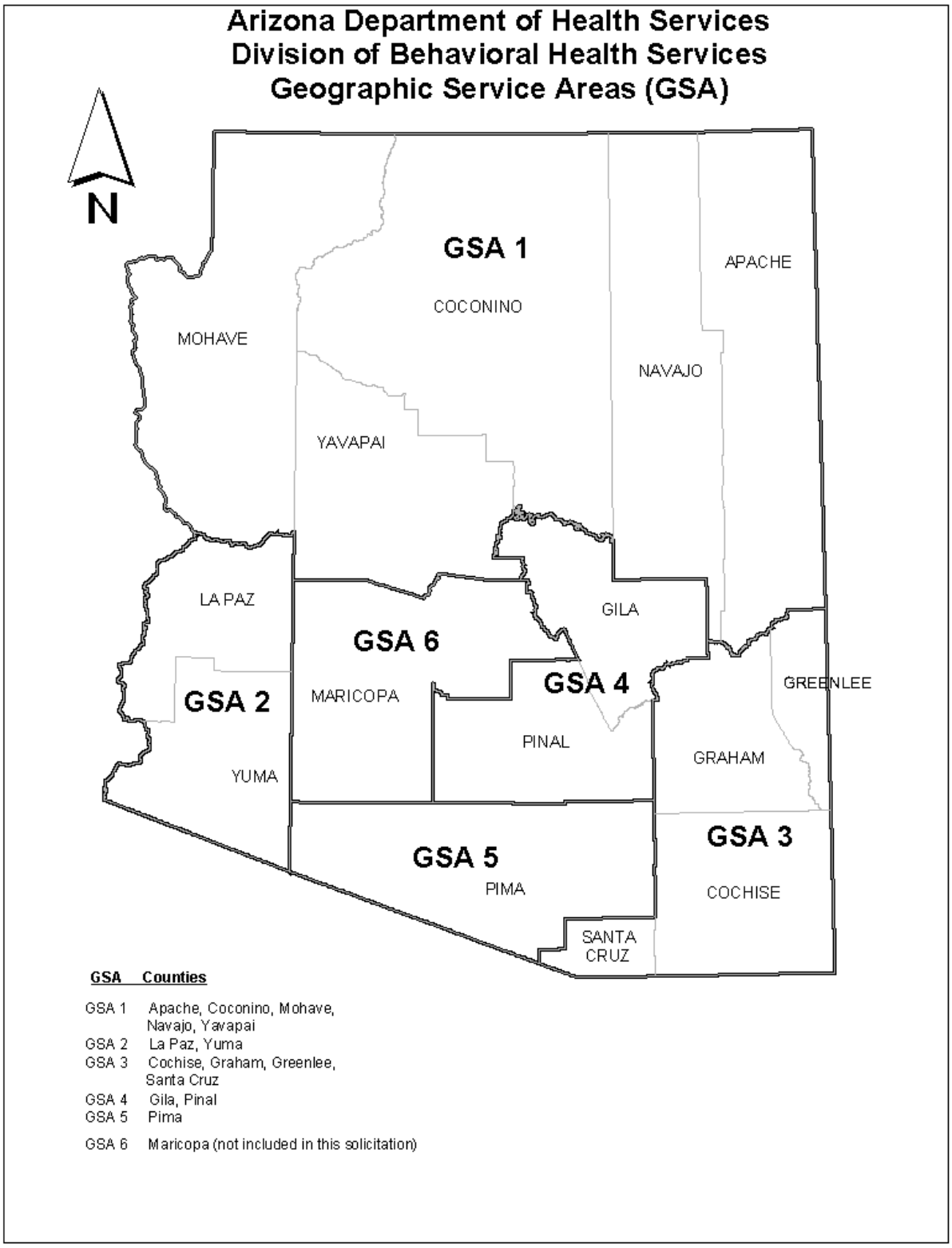
The purpose of this databook is to provide interested parties with summarized demographic, enrollment, eligibility, encounter, financial, diagnosis prevalence, zip code distribution, complaint resolution data, and grievance and appeals data for Greater Arizona. Potential bidders can use this databook to supplement their own experience when reviewing the capitation rates presented in the RFP.

Disclaimer

The user of this databook is cautioned against relying solely on the data contained herein. The DHS and Mercer provide no guarantee, either written or implied, that this databook is 100 percent accurate or error-free.

In addition, HIPAA implementation was completed on October 1, 2003, resulting in the use of new codes in the encounter system. As such, this change in coding may or may not have resulted in completely accurate reporting of encounters.

Arizona Map with Counties



Report Descriptions

Data is presented by State Fiscal Year (SFY) for each Geographic Service Area (GSA) in Greater Arizona, unless otherwise noted. The DHS state fiscal year runs from July 1 through June 30. For example, SFY02 runs from July 1, 2001, through June 30, 2002. All data is presented for SFY01 through SFY03 when available. Demographic and enrollment data is presented for all programs.

Each of the below reports for the Title XIX, Title XXI, and Non-Title XIX/XXI programs, when applicable, are presented for the following populations:

- Title XIX Children Not Enrolled In CMDP,
- Title XIX Children Enrolled in CMDP,
- Title XIX SMI Adults,
- Title XIX GMH/SA Adults,
- Title XXI Children,
- Title XXI Adults,
- Title XXI HIFA II Adults,
- Title XIX DDD-ALTCS Children,
- Title XIX DDD-ALTCS Adults,
- Non-Title XIX/XXI Children,
- Non-Title XIX/XXI SMI Adults, and
- Non-Title XIX/XXI GMH/SA Adults.

Demographic Tables

The Title XIX and Title XXI Demographic Tables provide information regarding Greater Arizona behavioral health recipients for SFY01 through SFY03. All tables are populated to the extent that data was available.

Each Title XIX and Title XXI report is divided into two main sections: 1) AHCCCS eligibles and 2) enrolled behavioral health recipients. Both sections contain the following information. Each year shows recipient stratification within age bands, gender, and race/ethnicity. The age of each recipient was calculated at the end of each SFY. There are totals by age band for each gender, as well as totals by year for each race/ethnicity. The counts for each cell represent a recipient only once, eliminating possible multiple entry and exits to the system over the course of the SFY. The data represent data extracts for the month of June each year.

AHCCCS Eligibles

The AHCCCS eligibility portion of the report represents all persons who are participants of AHCCCS and have behavioral health benefits as reported to the DHS by AHCCCS. The AHCCCS Adults Eligibility are the same numbers for Seriously Mentally Ill (SMI) and General Mental Health/Substance Abuse (GMH/SA).

The information for the DDD-ALTCS reports is derived from a separate roster from that agency. The population of eligible counts represents the entire DDD-ALTCS roster.

Enrolled Behavioral Health Recipients
This section depicts the enrolled behavioral health recipients. The information was extracted from the DHS computer systems.

Historical Rates
Historical capitation rates for each program and population are provided for SFY01 through SFY05. Historical capitation rates are those paid to the contractor. The rates in these tables are presented by GSA and population.

Encounter and Financial Data Reports
Encounter data was taken from the DHS encounter files. Financial information was taken from contractor submitted financial statements. Encounter data presented in this databook is for dates of service from July 1, 2000, through June 30, 2003, and received and processed through May 31, 2004.

The utilization and average cost per service data in this databook is based on encounter data submitted by participating contractors to the DHS. An encounter is a record of services provided to DHS enrolled persons. Mercer Government Human Services Consulting (Mercer) with assistance from DHS, compiled the encounter submissions and summarized them in a series of tables for the Offeror to use. Because providers may not have reported complete or completely accurate encounter data, the utilization and average cost per service tables may not represent actual experience. Consequently, despite considerable edits within the encounter validation process, the DHS cannot guarantee the reliability, accuracy, or validity of this data, and the Offeror should use this data with caution.

Member Months
Member months are reported for the populations and are the counts of the number of categorically eligible people in each program, for each month of capitated payments. This is the total number of months for all eligibles within the specified population within each SFY. For the Non-Title XIX/XXI population, the enrollee months are shown, which are counts of the number of enrolled people in the program for each month within each SFY.

Unique Utilizers
This represents the number of individuals utilizing each service item at least once in the given time period. Individuals are counted only once per service item and time period, regardless of the number of times a particular service was accessed.

Units (Completed Utilization)
This represents total utilization, i.e., days or hours, for each service line item. Because the units shown in these tables represent broad categories of service, the units within each of the categories of service will not be uniform. For example, respite services may include encounters with units consisting of days and hours. Each of these would be counted as one unit and summed to derive the units for the entire COS. Units are completed using the same monthly completion factors as the encounter dollars.

Completed Encounter Dollars

This represents the total incurred encounter amount for each service item. These encounters were summarized based on date of service, category of service, and population. The dollar amounts shown in the tables are after the application of completion factors and therefore represent the total incurred amounts.

Annual Units per 1,000 Members

This represents the utilization divided by member months and then multiplied by 12,000. Mercer uses annual utilization per 1,000 to standardize the historical utilization by COS, allowing for direct comparisons of utilization, regardless of enrollment changes. It is calculated using the following formula:

[Completed Utilization / (Member Months)] x 12,000

Similar to the encounter dollars, the completed Annual Units per 1,000 used completion factors to account for any encounters that have not yet been reflected in the system.

Average Cost per Service (Unit Cost)

This is the average cost of each service line item. It is calculated using the following formula:

[Completed Encounter Dollars / Completed Utilization]

Encounter Cost PMPM/PEPM

This is total incurred encounter dollars expressed on a per member per month (PMPM) or per enrollee per month (PEPM) cost basis. PEPMs are shown for the Non-Title XIX/XXI population. It is calculated using the following formula:

[Annual Units per 1,000 x Unit Cost] / 12,000

Financial Statement Dollars

This represents the total estimated incurred amount for each service item as reported in the financial statements submitted by the existing contractors in each of the Greater Arizona GSAs. Dollars that are shown may or may not reflect expenditures gross of pharmacy rebates.

Financial Statement PMPM/PEPM

This represents the total estimated incurred amount for each service item PMPM/PEPM as reported in the financial statements submitted by the existing contractors in each of the Greater Arizona GSAs. PEPMs are shown for the Non-Title XIX/XXI population.

Summary of Historical Rates

This table summarizes the historical capitation rates paid to the existing contractors for all populations in each of the Greater Arizona GSAs.

Summary of Title XIX, Title XXI, and Non-Title XIX/XXI Disbursements

These tables summarize the historical Title XIX, Title XXI, and Non-Title XIX/XXI disbursements made to the existing contractors in each of the Greater Arizona GSAs for SFY01 through SFY03.

Rate Setting Methodology

This section contains a description of the rate setting methodology used for the SFY06 rate update, and for the rate development for SFY05 and SFY04.

Summary of Revenues and Expenses

These tables show the summarized revenues and expenses by population for SFY01 through SFY03. Aggregate totals may or may not be net of pharmacy rebates, please refer to comments in this section for further information.

Diagnosis Prevalence

The Title XIX/XXI Diagnosis Prevalence Tables provide information regarding Greater Arizona behavioral health recipients for SFY03. The information was extracted from the DHS computer systems. The data represents diagnoses for unduplicated clients. Tables are populated to the extent that data was available.

Each report is divided into two main sections: 1) Diagnosis from Clinical Data Submissions and 2) Diagnosis from Encounters. The data represent data extracts for SFY03 and are presented by population.

Diagnosis from Clinical Data Submissions

This section contains the diagnosis code and the description of the twenty most prevalent diagnoses, the count of clients for each primary diagnosis, and the count of clients with any of those twenty diagnoses as a secondary diagnosis.

Diagnosis from Encounters

This section contains the diagnosis code and the description of the twenty most prevalent diagnoses, and the count of clients for each primary diagnosis. The data is extracted for SFY03. The number of clients with a secondary diagnosis is not available from the encounter file.

The two adult reports identify diagnosis prevalence by SMI and GMH/SA.

Zip Code Distribution Table

The Zip Code Distribution Table provides information regarding each of the Greater Arizona GSAs AHCCCS eligible persons and behavioral health recipients for June 2003. The table is populated to the extent that data was available. The information was extracted from the DHS computer systems.

The Title XIX/XXI AHCCCS Eligible Counts represents the number of clients with AHCCCS eligibility within a zip code. The Title XIX/XXI Enrolled Counts represents the number of enrolled behavioral health recipients within a zip code. The Non-Title XIX/XXI Enrolled Counts represents the number of behavioral health recipients that are not AHCCCS eligible within a zip code.

Complaint Resolution Data

The Complaint Resolution Table provides information regarding reported problems for Greater Arizona behavioral health recipients for Calendar Years 2002 and 2003. The information was extracted from the DHS computer systems. The complaint resolutions are organized according to the category of service based upon the Covered Behavioral Health Services Guide. The table is populated to the extent that data was available.

The report shows the counts by Complaint Resolution Categories reported to the DHS. The problems are further stratified between Children, SMI, and GMH/SA.

Grievance and Appeals Data

This section presents data for Grievance and Appeals for SFY03. The data was run as of June 24, 2004. These reports represent SMI Grievances, Member Appeals, and Provider Claim Disputes.

Data is presented by GSA, and states the issue, the total number of each type of case, the level of the process the final resolution occurred in, number of pending cases, and the average number of days to process the case.

Prevention Services

This section presents data for Prevention services. The tables include the dollar amounts for Prevention services from the financial statements for SFY01 through SFY03.

Adjustments to Data

The base data included within this databook consists of encounter data for Greater Arizona for July 1, 2000, through June 30, 2003. In addition, financial reports spanning the same time period are used to supplement the encounter data.

Completion Factors

The base encounter data includes encounters received through May 31, 2004, with incurred dates from July 1, 2000, through June 30, 2003. Completion factors to account for unpaid claims liability were developed and applied by month. Completion factors were developed separately for behavioral health non-drug benefits and prescription drugs. The separate and overall (behavioral health non-drug benefits and prescription drugs combined) completion factors by GSA and SFY for Title XIX and Non-Title XIX/XXI are as follows:

GSA 1

	Title XIX			Non-Title XIX/XXI		
	SFY01	SFY02	SFY03	SFY01	SFY02	SFY03
Behavioral Health Benefits	1.000	1.000	1.010	1.000	1.000	1.016
Prescription Drugs	1.000	1.000	1.000	1.000	1.000	1.000
Overall	1.000	1.000	1.008	1.000	1.000	1.012

GSA 2

	Title XIX			Non-Title XIX/XXI		
	SFY01	SFY02	SFY03	SFY01	SFY02	SFY03
Behavioral Health Benefits	1.000	1.000	1.000	1.000	1.000	1.000
Prescription Drugs	1.000	1.000	1.000	1.000	1.000	1.000
Overall	1.000	1.000	1.000	1.000	1.000	1.000

GSA 3

	Title XIX			Non-Title XIX/XXI		
	SFY01	SFY02	SFY03	SFY01	SFY02	SFY03
Behavioral Health Benefits	1.000	1.000	1.005	1.000	1.000	1.006
Prescription Drugs	1.000	1.000	1.000	1.000	1.000	1.000
Overall	1.000	1.000	1.004	1.000	1.000	1.006

GSA 4

	Title XIX			Non-Title XIX/XXI		
	SFY01	SFY02	SFY03	SFY01	SFY02	SFY03
Behavioral Health Benefits	1.000	1.000	1.025	1.000	1.000	1.020
Prescription Drugs	1.000	1.000	1.011	1.000	1.000	1.000
Overall	1.000	1.000	1.023	1.000	1.000	1.018

GSA 5

	Title XIX			Non-Title XIX/XXI		
	SFY01	SFY02	SFY03	SFY01	SFY02	SFY03
Behavioral Health Benefits	1.000	1.000	1.016	1.000	1.000	1.023
Prescription Drugs	1.000	1.000	1.000	1.000	1.000	1.000
Overall	1.000	1.000	1.012	1.000	1.000	1.018

Retro Claims

DHS identified a significant number of claims prior to February 2002 that were classified as Non-Title XIX/XXI claims which are actually valid Title XIX claims. DHS refers to these claims as "retro claims". In the submission process there are four criteria a claim must pass in order to be coded as a Title XIX claim. They are the member's name, the member's date of birth, the member's social security number, and the DHS enrollment number. The "retro claims" matched three of the four criteria and therefore DHS believes these claims should be classified as Title XIX claims.

Since these claims will be classified as Title XIX claims, they need to be reflected in the base data to account for all Title XIX services provided by the contractors. The retro claims provided were by contractor and age of the client. The claims were then separated by children and adult categories. The adult claims were then allocated into the SMI and GMH/SA programs using the distribution of the base encounter claims.

Case Management Encounters

From July 1, 2000, through October 1, 2001, contractors were not required to submit case management encounters into the encounter system. Case management expenses for this time period were obtained from the financial statements of each contractor. The data was obtained for the Title XIX population by program (Children, SMI, and GMH/SA). These dollars were then added to the base data under the Support Services category of service for the appropriate months. Case management units were also added to the base data to Support Services. Units were calculated based on the dollars obtained from the financial statements and the unit cost for case management services as of October 2001. There are four HCPC procedure codes combined with modifiers that DHS uses to identify four types of case management services, each with a distinct unit cost. An overall weighted unit cost was derived based on the distribution of service dollars for each of the four procedure codes for the calendar year 2002. This weighted unit cost was then used in

conjunction with the case management dollars to model the number of units to be added to the base data for the time period July 1, 2000, through October 1, 2001.

CMDP Capitation Rates

Capitation rates specific for the Title XIX CMDP population were developed for the first time in SFY05. Prior to SFY05, an overall Title XIX children's capitation rate was paid to each contractor.

Rate Setting Methodology

SFY06 Rate Update Methodology

Behavioral Health Services State Fiscal Year 2006 Capitation Rate Update for the Title XIX Program

Introduction/Background

The DHS contracted with Mercer to develop actuarially sound capitation rates for Greater Arizona for SFY06. Rates were developed for the Title XIX program.

Overview of Rate Setting Methodology

Mercer assisted DHS with the development of a risk-based capitation rate update methodology for Greater Arizona that complies with the Centers for Medicare & Medicaid Services' (CMS's) requirements and the regulations under the Balanced Budget Act of 1997 (BBA). As it relates to the rate-setting methodology checklist and Medicaid managed care regulations (42 CFR 438.6) effective August 13, 2002, CMS requires that capitation rates be "actuarially sound." CMS defines actuarially sound rates as meeting the following criteria:

- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and
- have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

Actuarially sound capitation rates were developed for the contract period July 1, 2005, through June 30, 2006, covering SFY06. Mercer has utilized actuarially sound principles and practices in the development of these capitation rates.

The goal of capitation rate development is to take experience that is available during the base period and convert that experience, using actuarial principles, into appropriate baseline data for the contract period. Once the baseline data is determined, adjustments including trend, program changes, and provisions for administration and underwriting profit/risk/contingency are applied in order to determine actuarially sound capitation rates.

The capitation rate update process was divided into the following:

1. Gather base data
    - Projected per-member-per-month (PMPM) claim costs by GSA for SFY05 (prior to SFY05 program changes) from the approved SFY05 capitation rates were used as the claims base
    - For GSA 1, PMPM costs were reduced on a budget neutral basis to account for the expanded eligibility base in SFY06

2. Calculate SFY06 actuarially sound rates
   - Apply trend factors to bring Base SFY05 PMPM claims from above forward 12 months from SFY05 to SFY06
   - Apply appropriate adjustment for various SFY05 and SFY06 program changes
   - Certify actuarial equivalence of the populations
   - Add provisions for administration and underwriting profit/risk/contingency

The end result of this capitation rate update process, completed jointly by DHS and Mercer, is actuarially sound capitation rates for SFY06.

Actuarially sound capitation rates were developed for each of the following populations, Children (CMDP and non-CMDP, separately), SMI, and GMH/SA.

Base Costs

As this is a rate update, projected PMPM claim costs by GSA for SFY05 (prior to the application of SFY05 program changes) from the approved SFY05 capitation rates were used as the base claim costs for the SFY06 rate update. In addition, for GSA 1, PMPM costs were reduced on a cost neutral basis to account for the expanded eligibility base to be used in SFY06.

Trend

Trend is an estimate of the change in the cost of providing a specific set of benefits over time, resulting from both unit cost (price) and utilization changes. Trend factors are used to estimate the cost of providing services in some future year (contract year) based on the cost incurred in a prior (base) year.

In order to determine actuarially sound capitation rates, Mercer projected the base data forward to reflect utilization and unit cost trend by population, behavioral health (non-pharmacy) and pharmacy COS, and GSA. Mercer calculated trends from the historical encounter data. The historical data that was used as a basis for trend development did not appropriately reflect the costs related to more recent program changes, which made it necessary for Mercer to include separate adjustments in the rate development process to account for such changes (these adjustments are discussed in later sections of this letter). Mercer also utilized its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs. Contractor submitted financial data trends were also reviewed. Although the trends were developed using several years of historical data, the trends factors were applied only to the SFY05 base claims data, bringing it forward 12 months to SFY06.

Program Changes

DHS and Mercer reviewed the program changes that will have a material effect upon the cost, utilization, or demographic structure of the program during the contract period SFY06, whose effect was not included within the base claims data described above. Mercer reviewed the following information:

- programmatic changes affecting covered services and eligibility; and
- programmatic changes affecting provider reimbursement rates.

Therapeutic Foster Care

There are an estimated 250 children in therapeutic foster care that were covered by the Department of Economic Security (DES). These children are expected to shift in claim cost responsibility to DHS.

DES Kids in Counseling

There are approximately 860 children who receive counseling through DES that will transition to DHS. For SFY06 rate development, Mercer has assumed that 85 percent of these eligible children will transition. Actual counts of children by GSA were obtained and used to develop the adjustment for each GSA.

DES Kids in Level 1, 2, and 3 Out of Home Care

There are several DES children who are eligible for Title XIX services that were covered by the DES. These children's services were paid for using other funds rather than Title XIX funds. Most of these children are located in inpatient facilities. The State of Arizona has determined that these children are eligible to access the services of the behavioral health system.

Youths in Detention

There are currently several children who are eligible for Title XIX services that are anticipated to be confined in detention centers. These children incur higher costs than the average Title XIX child. An adjustment is therefore needed to reflect these increased costs in SFY06.

Converted SMI Users

Under the current law and agreements with the plaintiffs in the lawsuit, **Arnold v. ADHS**, Non-Title XIX SMI clients are entitled to the same services as the Title XIX SMI clients. DHS has converted a significant number of these Non-Title XIX clients to Title XIX eligibility. In 2002, the Arizona Legislature eliminated laws previously exempting the SMI population from being required to comply with all Title XIX eligibility requirements. This action will provide the incentive for those clients seeking to continue to receive the full array of Title XIX services to convert to the Title XIX program.

DHS estimates that there are approximately 334 Non-Title XIX SMI users that will convert to the Title XIX program based on historical conversion data. The converted users were allocated among the GSAs based upon the current SMI membership distribution.

Medicare Part D

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), a prescription drug benefit will be provided for the Medicare eligible population. This change will be effective January 1, 2006. Under this program, prescription drug expenditures for a state Medicaid program will be reduced. Historical dual eligible prescription drug expenditures were reviewed and used to make an estimate of the impact of MMA to the SFY06 capitation rates.

Administration and Underwriting Profit/Risk/Contingency

The actuarially sound capitation rates developed include provisions for contractor administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer reviewed current contractor financial reports. Increased operational efficiencies are expected. The component for administration and underwriting profit/risk/ contingency is calculated as a percentage of the final capitation rate.

Risk Corridors and Performance Incentive

DHS has in place a risk corridor arrangement that provides motivation for contractors to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for contractors to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed SFY06 DHS risk corridor approach provides for gain/loss risk sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. In Mercer's professional opinion, the risk corridor and performance incentive methodologies utilized by DHS are actuarially sound.

Certification of Final Rates

Mercer certifies that the attached rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual contractor costs will differ from these projections. Mercer has developed these rates on behalf of DHS to demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations

Behavioral Health Services State Fiscal Year 2006 Capitation Rate Update for the Title XXI Program

Introduction/Background

DHS contracted with Mercer to develop actuarially sound capitation rates for each of its Greater Arizona GSAs for SFY06. Rates were developed for the Title XXI and HIFA II programs.

The State Children's Health Insurance Program (SCHIP), titled "KidsCare" and also known as Title XXI, provides health insurance to uninsured children under 19 years of age whose families gross income is at or below 200 percent of the federal poverty level. The KidsCare benefit package is identical to what is offered to State Employees.

Base Costs

Mercer has developed capitation rates for the Title XXI and HIFA II populations for SFY06. Because the membership in these populations is quite low, encounter data from their claims is not sufficient. Based upon review of historical financial statements, Title XXI individuals' claim costs generally represent about 33–38 percent of Title XIX claim costs. Based on this observation, DHS and Mercer agreed to use the Title XIX claim cost PMPM values as the base data for the Title XXI rates.

From these base PMPMs, Mercer applied an acuity adjustment factor to the PMPMs to derive the Title XXI capitation rates. The acuity adjustment factors were 0.38 for Children and 0.33 for the SMI population.

Similar to the Title XXI rates, Mercer used the Title XIX claim cost PMPMs as the base PMPM for the HIFA II capitation rates. From there, an acuity adjustment factor of 0.33 was applied to both the SMI and GMH/SA populations.

Administration and Underwriting Profit/Risk/Contingency

The actuarially sound capitation rates developed include provisions for contractor administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer also reviewed current contractor financial reports. Increased operational efficiencies are expected. The component for administration and underwriting profit/risk/contingency is calculated as a percentage of the final capitation rate.

Risk Corridors and Performance Incentive

DHS has in place a risk corridor arrangement that provides motivation for contractors to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for contractors to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed SFY06 DHS risk corridor approach provides for gain/loss risk sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. In Mercer's professional opinion, the risk corridor and performance incentive methodologies utilized by DHS are actuarially sound.

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SFY05 Rate Setting Methodology

Behavioral Health Services State Fiscal Year 2005 Capitation Rates for the Title XIX Program

Introduction/Background

The DHS contracted with Mercer to develop actuarially sound capitation rates for each of its contractors for SFY05. Rates were developed for the Title XIX program.

Overview of Rate-Setting Methodology

Mercer assisted DHS with the development of a risk-based capitation rate methodology for contractors that complies with the Centers for Medicare & Medicaid Services' (CMS') requirements and the regulations under the Balanced Budget Act of 1997 (BBA). As it relates to the rate-setting methodology checklist and Medicaid managed care regulations (42 CFR 438.6) effective August 13, 2002, CMS requires that capitation rates be "actuarially sound." CMS defines actuarially sound rates as meeting the following criteria:

- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and
- have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

Actuarially sound capitation rates were developed for the contract period July 1, 2004, through June 30, 2005, covering SFY05. Mercer has utilized actuarially sound principles and practices in the development of these capitation rates.

The goal of capitation rate development is to take experience that is available during the base period and convert that experience, using actuarial principles, into appropriate baseline data for the contract period. Once the baseline data is determined, adjustments including trend, program changes, and provisions for administration and underwriting profit/risk/contingency are applied in order to determine actuarially sound capitation rates.

The capitation rate development process was divided into the following steps.

1. Calculate base data
    - Collect and analyze contractor encounter data from SFY00 through the first half of SFY04
    - Apply separate completion factors by month and contractor, to account for any unpaid claims liability
    - Apply appropriate data smoothing adjustments to account for missing data
    - Utilize actual member months from SFY03 and the Base SFY03 total claim costs, to calculate Base SFY03 per-member-per-month (PMPM) values
    - Review contractor financial statements to determine if adjustments are needed to the Base SFY03 total claim costs

- Perform budget neutral relational modeling

2. Calculate SFY05 actuarially sound rates
   - Apply acuity adjustment to account for changes in Behavioral Health penetration rates
   - Apply trend factors to bring final Base SFY03 PMPM claims forward 24 months from SFY03 to SFY05
   - Apply appropriate adjustment for various program changes
   - Certify actuarial equivalence of the populations
   - Add provisions for administration and underwriting profit/risk/contingency

The end result of this capitation rate development process, completed jointly by DHS and Mercer, is actuarially sound capitation rates for SFY05.

Base Costs

The base data consisted of encounter data from all contractors for July 1, 2002, through June 30, 2003. Given significant population growth in the Arizona Medicaid program, and continued emphasis on increased access to providers, this current timeframe and its fully credible aggregate membership was determined to be the most appropriate. Use of this SFY03 period allowed for six months of encounter run-out. In addition, financial reports spanning SFY03 were used to supplement the encounter data.

The DHS program falls under Arizona's 1115 waiver. 1115(a)(2) services are considered State Plan services for 1115 populations for the duration of the demonstration waiver, and hence no adjustment is required. The base data provided by DHS to Mercer includes only State Plan approved services. Mercer used the lower value of the encounters or the submitted financial reports on an aggregate contractor specific basis for Base SFY03 total claim costs.

Completion Factors

The base encounter data included encounters received through December 31, 2003, with incurred dates from July 1, 2002, through June 30, 2003. Completion factors to account for unpaid claims liability, and thus estimate ultimate incurred liability, were developed separately for each contractor, and were applied by month. Completion factors were derived separately for behavioral health benefits and prescription drugs. In instances where the lower submitted financial report figures were used, the ultimate incurred liability was already derived.

Data Smoothing

The base data was reviewed for consistency on a completed monthly incurred basis. This review was conducted at a contractor and category of service (COS) (pharmacy and non-pharmacy) level of detail. There were months for two contractors where the data was determined missing and a net addition of dollars was necessary. The data smoothing resulted in a more complete picture of the encounter submission patterns typically observed in the program. Data smoothing was only applied to the encounter data.

Budget Neutral Relational Modeling

While in aggregate the population and encounter data was fully credible in the base period, there were regional distortions which required additional smoothing. Mercer applied budget neutral relational modeling to account for these variances. No dollars were gained or lost through this process.

Behavioral Health Penetration — Acuity Adjustment

A significant increase in penetration in the behavioral health program has been observed in the children and GMH/SA populations. Greater proportions of those eligible populations are accessing the behavioral health system. These increases have contributed to the projected increase in utilization for these populations reflected in overall claim costs. For most contractors, the exact opposite has happened for the SMI population. The following table summarizes the actual/projected penetration change over a one-year time period (SFY03 to SFY04). This change was applied as an acuity adjustment to the relationally modeled estimate SFY03 claim costs.

Trend

Trend is an estimate of the change in the cost of providing a specific set of benefits over time, resulting from both unit cost (price) and utilization changes. Trend factors are used to estimate the cost of providing services in some future year (contract year) based on the cost incurred in a prior (base) year.

In order to determine actuarially sound capitation rates, Mercer projected the base data forward to reflect utilization and unit cost trend by population, behavioral health (non-pharmacy) and pharmacy COS, and contractor. Mercer calculated trends from the historical encounter data. The historical data that was used as a basis for trend development did not appropriately reflect the costs related to more recent program changes, which made it necessary for Mercer to include separate adjustments in the rate development process to account for such changes (these adjustments are discussed in later sections of this letter). Mercer also utilized its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs. Contractor submitted financial data trends were also reviewed. Although the trends were developed using several years of historical data, the trends factors were applied only to the SFY03 base data, bringing it forward 24 months to SFY05.

Unit cost trends were applied to the SFY03 base data (after the applied acuity adjustment) to bring it forward to SFY04. A trend to account for utilization changes between SFY03 and SFY04 was not used since the acuity adjustment was used to adjust for utilization changes during this time period. A combined unit cost and utilization trend was then applied to bring the PMPMs forward from SFY04 to SFY05. These trends should be reviewed in conjunction with the corresponding acuity adjustment factors.

Program Changes

DHS and Mercer reviewed the program changes that will have a material effect upon the cost, utilization, or demographic structure of the program during the contract period SFY05, whose effect was not included within the base data. Mercer reviewed the following information:

- programmatic changes affecting covered services and eligibility; and
- programmatic changes affecting provider reimbursement rates.

Therapeutic Foster Care

There are an estimated 250 new children in therapeutic foster care that are currently covered by the Department of Economic Security (DES). These children are expected to shift in claim cost responsibility to DHS.

DES Kids in Counseling

There are approximately 860 children currently receiving counseling through DES that will transition to DHS. For SFY05 rate development, Mercer has assumed that 85 percent of these eligible children will transition. Actual counts of children by contractor were obtained and used to develop the adjustment for each contractor.

DES Kids in Level 1, 2, and 3 Out of Home Care

There are currently several DES children who are eligible for Title XIX services that are being covered by the DES. These children's services are paid for using other funds rather than Title XIX funds. Most of these children are located in inpatient facilities. The State of Arizona has determined that these children are eligible to access the services of the behavioral health system. As a result, DES began transitioning these children into the contractor system for covered behavioral health services beginning in July 2002. It is estimated that most of these DES kids had been transitioned into the contractor system by December 2002. However, only a portion of the claims costs associated with these transitioned children are reflected in the base claims data. As a result, an adjustment is needed to reflect their ongoing costs in SFY 2005.

Converted SMI Users

Under the current law and agreements with the plaintiffs in the lawsuit, **Arnold v. ADHS**, Non-Title XIX SMI clients are entitled to the same services as the Title XIX SMI clients. DHS has converted a significant number of these Non-Title XIX clients to Title XIX eligibility. In 2002, the Arizona Legislature eliminated laws previously exempting the SMI population from being required to comply with all Title XIX eligibility requirements. This action will provide the incentive for those clients seeking to continue to receive the full array of Title XIX services to convert to the Title XIX program.

DHS estimates that there are approximately 334 Non-Title XIX SMI users that will convert to the Title XIX program in SFY05 based on historical conversion data. The converted users were allocated among the contractors based upon the current SMI membership distribution.

Administration and Underwriting Profit/Risk/Contingency

The actuarially sound capitation rates developed include provisions for contractor administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer reviewed current contractor financial reports. Increased operational efficiencies are expected. The component for administration and underwriting profit/risk/ contingency is calculated as a percentage of the final capitation rate.

Risk Corridors and Performance Incentive

DHS has in place a risk corridor arrangement with the contractors that provides motivation for the contractors to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the contractors to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed SFY05 DHS risk corridor approach provides for gain/loss risk sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. In Mercer's professional opinion, the risk corridor and performance incentive methodologies utilized by DHS are actuarially sound.

Certification of Final Rates

Mercer certifies that the above and attached rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual contractor costs will differ from these projections. Mercer has developed these rates on behalf of DHS to demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations

Behavioral Health Services State Fiscal Year 2005 Capitation Rates for the Title XXI and HIFA II Programs

Introduction/Background

DHS contracted with Mercer to develop actuarially sound capitation rates for each of its contractors for SFY05. Rates were developed for the Title XXI and HIFA II programs.

The State Children's Health Insurance Program (SCHIP), titled "KidsCare" and also known as Title XXI, provides health insurance to uninsured children under 19 years of age whose families gross income is at or below 200 percent of the federal poverty level. The KidsCare benefit package is identical to what is offered to State Employees.

Base Costs

Mercer has developed capitation rates for the Title XXI and HIFA II populations for SFY05. Because the membership in these populations is quite low, encounter data from their claims is not sufficient. Based upon review of historical financial statements, Title XXI individuals' claim costs generally represent about 33–38 percent of Title XIX claim costs. Based on this observation, DHS and Mercer agreed to use the Title XIX claim cost PMPM values as the base data for the Title XXI rates.

From these base PMPMs, Mercer applied an acuity adjustment factor to the PMPMs to derive the Title XXI capitation rates. The acuity adjustment factors were 0.38 for Children and 0.33 for the SMI population.

Similar to the Title XXI rates, Mercer used the Title XIX claim cost PMPMs as the base PMPM for the HIFA II capitation rates. From there, an acuity adjustment factor of 0.33 was applied to both the SMI and GMH/SA populations.

Administration and Underwriting Profit/Risk/Contingency

The actuarially sound capitation rates developed include provisions for contractor administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer also reviewed current contractor financial reports. Increased operational efficiencies are expected. The component for administration and underwriting profit/risk/contingency is calculated as a percentage of the final capitation rate.

Risk Corridors and Performance Incentive

DHS has in place a risk corridor arrangement with the contractors that provides motivation for the contractors to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the contractors to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed SFY05 DHS risk corridor approach provides for gain/loss risk sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. In Mercer's professional opinion, the risk corridor and performance incentive methodologies utilized by DHS are actuarially sound.

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SFY04 Rate Setting Methodology

Behavioral Health Services State Fiscal Year 2004 Capitation Rates for the Title XIX Program

Introduction/Background

The DHS contracted with Mercer to develop actuarially sound capitation rates for each of its contractors for SFY04. Rates were developed for the Title XIX program.

Overview of Rate-Setting Methodology

Mercer assisted DHS with the development of a risk-based capitation rate methodology for contractors that complies with the CMS's requirements and the regulations under the BBA. As it relates to the rate-setting methodology checklist and Medicaid managed care regulations (42 CFR 438.6) effective August 13, 2002, CMS requires that capitation rates be "actuarially sound." CMS defines actuarially sound rates as meeting the following criteria:

- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and
- have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

Actuarially sound capitation rates were developed for the contract period July 1, 2003, through June 30, 2004, covering SFY04. Mercer has utilized actuarially sound principles and practices in the development of these capitation rates.

The goal of capitation rate development is to take experience that is available during the base period and convert that experience, using actuarial principles, into appropriate baseline data for the contract period. Once the baseline data is determined, adjustments including trend, program changes, and provisions for administration and underwriting profit/risk/contingency are applied in order to determine actuarially sound capitation rates.

The capitation rate development process was divided into the following:

1. Calculate base data
   - Collect and analyze contractor encounter data from SFY00 through the first half of SFY03 (1HSFY03)
   - Apply separate completion factors by month and contractor, to account for any unpaid claims liability
   - Utilize actual member months from 1HSFY03 and the Base 1HSFY03 total claim costs, to calculate Base 1HSFY03 per-member-per-month (PMPM) values

- Review contractor financial statements to determine if adjustments are needed to the Base 1HSFY03 total claim costs

2. Calculate SFY04 actuarially sound rates
   - Apply trend factors to bring final Base 1HSFY03 PMPM claims forward 15 months from 1HSFY03 to SFY04
   - Apply appropriate adjustment for various program changes
   - Certify actuarial equivalence of the populations
   - Add provisions for administration and underwriting profit/risk/contingency

The end result of this capitation rate development process, completed jointly by DHS and Mercer, is actuarially sound capitation rates for SFY04.

Actuarially sound capitation rates were developed for each of the following populations, Children, SMI, and GMH/SA.

Base Costs

The base data consisted of encounter data from all contractors for July 1, 2002, through December 31, 2002. Given significant population growth in the Arizona Medicaid program, and continued emphasis on increased access to providers, this current timeframe and its fully credible aggregate membership was determined to be the most appropriate. In addition, financial reports spanning the same time period were used to supplement the encounter data. The base data provided by DHS to Mercer includes only state-plan approved services. Mercer used the lower value of the submitted encounters or the submitted financial reports for Base 1HSFY03 total claim costs.

Completion Factors

The base encounter data included encounters received through March 31, 2003, with incurred dates from July 1, 2002, through December 31, 2002. Completion factors to account for unpaid claims liability, and thus estimate ultimate incurred liability, were developed separately for each contractor, and were applied by month. In instances where the lower submitted financial report figures were used, the ultimate incurred liability was already derived. Completion factors were derived separately for behavioral health benefits and prescription drugs.

Behavioral Health Penetration

A significant increase in penetration in the behavioral health program has been observed. A greater proportion of the eligible population is accessing the behavioral health system. This increase has contributed to the projected increase in utilization reflected in overall claim cost trend (discussed below).

Trend

Trend is an estimate of the change in the cost of providing a specific set of benefits over time, resulting from both unit cost (price) and utilization changes. Trend factors are used to estimate the cost of providing services in some future year (contract year) based on the cost incurred in a prior (base) period.

In order to determine actuarially sound capitation rates, Mercer projected the base data forward to reflect combined utilization and unit cost trend by population, major COS and contractor. These trends were then weighted together based on the proportion of dollars in each COS. Mercer calculated trends from the historical encounter data. The historical data that was used as a basis for trend development did not appropriately reflect the costs related to more recent program changes and add-ons, which made it necessary for Mercer to include separate adjustments in the rate development process to account for such changes and add-ons (these adjustments are discussed in later sections of this report). Mercer also utilized its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs. Contractor submitted financial data trends were also reviewed. Although the trends were developed using several years of historical data, the trends factors were applied only to the 1HSFY03 base data, bringing it forward 15 months to SFY04.

Program Changes

DHS and Mercer reviewed the program changes that will have a material effect upon the cost, utilization, or demographic structure of the program during the contract period SFY04, whose effect was not included within the base data. Mercer reviewed the following information:

- programmatic changes affecting covered services and eligibility; and
- programmatic changes affecting provider reimbursement rates.

Proposition 204

Proposition 204 changed the DHS eligibility criteria, allowing individuals and families with larger incomes to enroll. There were various stages of eligibility requirements implemented from April 2001 through October 2001. In Mercer's opinion, the base data provides an accurate representation of the impact on costs for Proposition 204 members and Mercer has therefore not made any special adjustment.

Therapeutic Foster Care

There are an estimated 242 new children in therapeutic foster care that are currently covered by the DES. Of these 242 children, 238 are estimated eligible to shift in claim cost responsibility to DHS. Mercer has assumed that 85 percent of these eligible children will phase into DHS during SFY04 starting in August 2003.

DES Kids in Counseling

There are approximately 282 children currently receiving counseling through DES that will transition to DHS. For SFY04 rate development, Mercer has assumed that 85 percent of these eligible children will actually transition. The children are assumed to phase into DHS over a 3 month period beginning August 2003.

DES Kids in Level 1 & 2 Out of Home Care

There are currently several DES children who are eligible for Title XIX services that are being covered by the DES. These children's services are paid for using other funds rather than Title XIX funds. Most of these children are located in inpatient facilities. The State of Arizona has determined that these children are eligible to access the services of the behavioral health system. As a result,

DES began transitioning these children into the contractor system for covered behavioral health services beginning in July 2002. It is estimated that most of these DES kids had been transitioned into the contractor system by December 2002. However, only a portion of the claims costs associated with these transitioned children are reflected in the base claims data. As a result, an adjustment is needed to reflect their ongoing costs in SFY04.

Converted SMI Users

Under the current law and agreements with the plaintiffs in the lawsuit, **Arnold v. ADHS**, Non-Title XIX SMI clients are entitled to the same services as the Title XIX SMI clients. DHS has converted a significant number of these Non-Title XIX clients to Title XIX eligibility. In 2002, the Arizona Legislature eliminated laws previously exempting the SMI population from being required to comply with all Title XIX eligibility requirements. This action will provide the incentive for those clients seeking to continue to receive the full array of Title XIX services to convert to the Title XIX program.

DHS estimates that there are approximately 375 Non-Title XIX SMI users that will convert to the Title XIX program in SFY04. The converted users were allocated among the contractors based upon the current SMI membership distribution. Estimated PMPM costs were developed.

IEP Placements (SEH Adjustment)

DHS contracts with contractors to provide services to children that are identified as Severely Emotionally Handicapped (SEH). The contractors that provide these services have historically been reimbursed by DHS with state-only funds.

DHS determined that a significant number of these SEH children are Title XIX eligible and estimates that approximately one-half of the SEH children currently receiving services are eligible for Title XIX. DHS began identifying these children as Title XIX eligible beginning in July 2002. It is estimated that most of these children were transitioned October through December, following the start of the school year in late August. Only a portion of the claims costs associated with these transitioned children are reflected in the base claims data.

Health Plan Referral Adjustment

During SFY03, a Title XIX acute care health plan instituted changes in prescription benefit coverage, which is anticipated to impact the DHS program. The health plan eliminated coverage of certain behavioral health prescription drugs from their formularies. These particular drugs are most often prescribed by primary care physicians, eliminating the need for affected individuals to utilize the contractor system to receive these drugs. Mercer anticipates that other Title XIX acute care health plans will implement similar changes in their prescription benefit coverage for SFY04.

Add-On Rates for HSRI

The ADHS commissioned a study by an outside consulting firm to estimate the appropriate level of care required for the SMI population, as required by the exit stipulation of the **Arnold v. ADHS** class action lawsuit. The study presents a care model that is designed to give SMI clients various levels of service depending upon each person's need. The model was developed with the intent that many clients could become independent and productive members of society with the proper

intensity of services for a limited time. Other clients may need care for an indefinite period and some may need intensive services throughout their life.

DHS is required to implement the model in the Human Services Research Institute (HSRI) study in an incremental manner to allow state and federal agencies to increase the funding gradually and give the system time to build capacity. The first increment, in SFY02, was approximately $12.2 million, which was used to provide additional services. An incremental amount was then added to the SFY03 capitation rates. Additional funding is required to continue to achieve the requirements contained in the Leff Report.

Administration/Underwriting Profit/Risk/Contingency

The actuarially sound capitation rates developed include provisions for contractor administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer reviewed current contractor financial reports. Increased operational efficiencies are expected. The component for administration and underwriting profit/risk/ contingency is calculated as a percentage of the final capitation rate.

Budget Neutral Relational Modeling

While in aggregate the population and claims data was fully credible in the base period, there were regional distortions which required smoothing. Mercer applied budget neutral relational modeling to account for these variances. No dollars were gained or lost through this process.

Risk Corridors

DHS has in place a risk corridor arrangement with the contractors that provides motivation for the contractors to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the contractors to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed SFY04 DHS risk corridor approach provides for gain/loss risk sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. In Mercer's professional opinion, this risk corridor methodology is actuarially sound.

Certification of Final Rates

Mercer certifies that the SFY04 capitation rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual contractor costs will differ from these projections. Mercer has developed these rates on behalf of DHS to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations. These rates may not be suitable for other purposes.

Behavioral Health Services State Fiscal Year 2004 Capitation Rates for the Title XXI and HIFA II Programs

Introduction/Background

The DHS contracted with Mercer to develop actuarially sound capitation rates for each of its contractors for SFY04. Rates were developed for the Title XXI and HIFA II programs.

The SCHIP, titled "KidsCare" and also known as Title XXI, provides health insurance to uninsured children under 19 years of age whose families gross income is at or below 200 percent of the federal poverty level. The KidsCare benefit package is identical to what is offered to State Employees.

Actuarially sound capitation rates were developed for each of the following populations, Title XXI Children, Title XXI SMI, HIFA II SMI, and HIFA II GMH/SA.

Base Costs

Mercer has developed capitation rates for the Title XXI and HIFA II populations for SFY04. Because the membership in these populations is quite low, encounter data from their claims is not sufficient. Based upon review of historical financial statements, Title XXI individuals' claim costs generally represent about 40–45 percent of Title XIX claim costs. Based on this observation, DHS and Mercer agreed to use the Title XIX relationally modeled claim cost PMPM values as the base data for the Title XXI rates.

From these base PMPMs, Mercer applied an acuity adjustment factor to the PMPMs to derive the Title XXI capitation rates. The acuity adjustment factors were 0.45 for Children and 0.40 for the SMI population.

Similar to the Title XXI rates, Mercer used the Title XIX relationally modeled claim cost PMPMs as the base PMPM for the HIFA II capitation rates. From there, an acuity adjustment factor of 0.40 was applied to both the SMI and GMH/SA populations.

Administration/Underwriting Profit/Risk/Contingency

The actuarially sound capitation rates developed include provisions for contractor administration. Mercer used its professional experience in working with numerous state Medicaid behavioral health and substance abuse programs in determining appropriate loads for administration and underwriting profit/risk/contingency. Mercer also reviewed current contractor financial reports. Increased operational efficiencies are expected. The component for administration and underwriting profit/risk/contingency is calculated as a percentage of the final capitation rate.

Risk Corridors

DHS has in place a risk corridor arrangement with the contractors that provides motivation for the contractors to appropriately manage expenses, yet provides financial protection against unmanageable losses. The risk corridor provides impetus for the contractors to operate efficiently and generate net income, but also provides for the return of any excessive profit to the State.

The proposed SFY04 DHS risk corridor approach provides for gain/loss risk sharing symmetry around the service revenue portion of the capitation rates. This risk corridor model is designed to be cost neutral, with no net aggregate assumed impact across all payments. In Mercer's professional opinion, this risk corridor methodology is actuarially sound.

Certification of Final Rates

Mercer certifies that the SFY04 capitation rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual contractor costs will differ from these projections. Mercer has developed these rates on behalf of DHS to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations. These rates may not be suitable for other purposes.